

Indiana State Department of Health  
State Form 51642 (11-04)

**1** Print firmly and neatly.     
**3** Fill in circles like this: ●     
**4** Print capital letters only and numbers completely inside boxes.     
**5** Please complete all items on form.

**2** Only use pens with blue or black ink.     
 Not like this: ✗     
 Mark mistakes like this: ✗     
 A 2 C 3     
**6** **Date format:** MM/DD/YY

<input type="text"/>																				<input type="text"/>																			
<b>Last Name</b>																																							
<input type="text"/>										<input type="text"/>					<input type="text"/>					<input type="text"/>																			
<b>First Name</b>										<b>MI</b>					<b>Phone Number</b>																								
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<b>City</b>															<b>State</b>					<b>ZIP Code</b>																			
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<b>County</b>															<b>Date of Birth</b>					<b>Age</b>																			
<b>Race:</b>															<b>Ethnicity:</b>										<b>Is Age in</b>														
<input type="radio"/> Asian															<input type="radio"/> White										<input type="radio"/> Hispanic or Latino					<input type="radio"/> Not Hispanic or Latino					<input type="radio"/> Unknown				
<input type="radio"/> Black or African American															<input type="radio"/> Other/Multiracial										<input type="radio"/> Days														
<input type="radio"/> American Indian or Alaska Native															<input type="radio"/> Unknown										<input type="radio"/> Months														
<input type="radio"/> Native Hawaiian or Other Pacific Islander															<input type="radio"/> Male										<input type="radio"/> Female					<input type="radio"/> Unknown					<input type="radio"/> Years				
<input type="text"/>															<input type="text"/>																								
<b>Occupation</b>															<b>Phone of Employer/School/Day Care</b>																								
<input type="text"/>															<input type="text"/>																								
<b>Name of</b> <input type="radio"/> Employer <input type="radio"/> School <input type="radio"/> Day Care																																							
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<b>City</b>															<b>State</b>					<b>ZIP Code</b>																			

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.3

PLAGUE CASE INVESTIGATION - Page 2 of 4

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Section 2. Clinical Information (continued)

1. Diagnostic Tests

PCR ☐ Positive ☐ Negative  
Culture ☐ Positive ☐ Negative  
FA ☐ Positive ☐ Negative

Sample(s) tested: \_\_\_\_\_

2. IgM Testing

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Acute Specimen Taken Acute Value

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Convalescent Specimen Taken Convalescent Value

Results:

☐ Significant Rise in IgM ☐ Pending  
☐ No Significant Rise in IgM ☐ Not Done  
☐ Indeterminate ☐ Unknown

3. IgG Testing

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Acute Specimen Taken Acute Value

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Convalescent Specimen Taken Convalescent Value

Results:

☐ Significant Rise in IgG ☐ Pending  
☐ No Significant Rise in IgG ☐ Not Done  
☐ Indeterminate ☐ Unknown

\_\_\_\_\_  
Physician/Hospital that Collected Specimen

\_\_\_\_\_  
Physician/Hospital Address

\_\_\_\_\_  
City State ZIP Code

\_\_\_\_\_  
Physician/Hospital Phone

Was the patient treated with  
antibiotics for this illness?

☐ Yes ☐ No

If Yes, antibiotic: \_\_\_\_\_

Start date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Was the patient hospitalized?

☐ Yes ☐ No

If Yes, admission date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Discharge date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did patient die?

☐ Yes ☐ No

Hospital: \_\_\_\_\_

Section 3. Risk Factors - Natural Exposure

During the week prior to onset of symptoms, did the patient:

Have contact with wild animals?

☐ Yes ☐ No

If Yes, type of activity: ☐ Playing ☐ Hunting ☐ Trapping ☐ Skinning/Dressing ☐ Other

\_\_\_\_\_  
If Other, specify

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date:

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Section 3. Risk Factors - Natural Exposure (continued)

Have contact with rodents, including rats or prairie dogs?

☐ Yes ☐ No

\_\_\_\_\_

If Yes, type of animal

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date

Sustain any bites from fleas?

☐ Yes ☐ No ☐ Unknown

If Yes, date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have contact with pets?

☐ Yes ☐ No

If Yes, date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If Yes, did pet have fleas?

☐ Yes ☐ No

Type of animal: \_\_\_\_\_

If Yes, was the pet ill?

☐ Yes ☐ No

Work in a laboratory handling plague bacteria?

☐ Yes ☐ No

If Yes, date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Location: \_\_\_\_\_

Travel outside of Indiana?

☐ Yes ☐ No

\_\_\_\_\_

If Yes, where

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date

Describe location of residence:

☐ Rural

☐ Suburban

☐ Urban

Section 4. Risk Factors - Suspicious Exposure

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of possible exposure

\_\_\_\_\_

Location(s), be as specific as possible

How was person exposed?

☐ Suspicious Aerosol

☐ Other

☐ Unknown

\_\_\_\_\_

If Aerosol, describe

\_\_\_\_\_

If Other, describe

Was there any prior threat of attack?

☐ Yes

☐ No

\_\_\_\_\_

If Yes, describe

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Section 4. Risk Factors - Suspicious Exposure (continued)

Were law enforcement authorities notified (only in the event of a suspicious exposure)?

☐ Yes ☐ No

If Yes, which branch:

☐ Local Police ☐ Local Sheriff ☐ State Police ☐ FBI ☐ Other, specify: \_\_\_\_\_

Was decontamination performed?

☐ Yes ☐ No

If Yes, type:

☐ Clothing Removal ☐ Hand Washing ☐ Shower/Shampoo ☐ Environmental Cleaning

Is this patient related to a confirmed exposure site?

☐ Yes ☐ No

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
If Yes, date

\_\_\_\_\_  
If Yes, where

Has this patient had contact with anyone else who has recently had an illness characterized by fever, pneumonia, or lymphadenopathy?

☐ Yes ☐ No ☐ Unknown

\_\_\_\_\_  
If Yes, name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Onset Date

Section 5. Comments/Follow-up

Comments:

\_\_\_\_\_  
Investigator Name

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Phone Number

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date